Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FOUNDATION SURGICAL HOSPITAL

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number
M4-08-6752-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 15, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier requesting CPT/HCPCS code for revenue code 250 for pharmacy items – these charges are bundled into primary codes + not paid separately seeking reimbursement for APC code 0274/0283 pharmacy/supply items not paid separately for a hospital."

Amount in Dispute: $962.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier EOBs attached."

Response Submitted by: Pappas & Suchma, PO BOX 66655, Austin, Texas 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2008	Outpatient Hospital Services	$962.92	$962.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for disputed services with reason code 16 – "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate." No indication was found of what information was requested or needed by the insurance carrier for adjudication. Review of the submitted information finds that the documentation is sufficient for adjudication. The insurance carrier's denial reasons are not supported.
2. A reference to an informal or voluntary insurance network was found on a submitted explanation of benefits for the disputed services; however, no documentation was found to support that the disputed services were subject to a contractual agreement between the parties to this dispute. Nevertheless, on January 6, 2011, the Division requested the respondent to provide any asserted contractual agreement between the parties, pursuant to former 28 Texas Administrative Code §133.307(f)(1), effective May 31, 2012, 37 *Texas Register* 3833, which states that "The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request. If the division does not receive the requested additional information within 14 days after receipt of the request, then the division may base its decision on the information available." Review of the submitted information finds no documentation to support that the insurance carrier, American Home Assurance, was granted access to the contractual fee arrangement between the health care provider and the alleged informal or voluntary insurance network. No documentation was found of a contract between the insurance carrier, American Home Assurance, and the alleged network. No documentation was found to support notification to the health care provider that the insurance carrier, American Home Assurance, was an authorized payor in the alleged network. A contractual fee agreement is therefore not supported between the parties in this dispute. The disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to facility services of an acute care hospital appropriately licensed by the Texas Department of State Health Services performed in an outpatient setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
    - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
    - Procedure code 62284 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 72265 has a status indicator of Q, which indicates conditionally packaged codes that may be separately paid only of criteria are met. As no status indicator T services were billed for this date, the criteria for separate payment are met for this service. This service is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 274, which, per OPPS Addendum A, has a payment rate of $481.46. This amount multiplied by 60% yields an unadjusted labor-related amount of $288.88. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $288.79. The non-labor related portion is 40% of the APC rate or $192.58. The sum of the labor and non-labor related amounts is $481.37. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $481.37. This amount multiplied by 200% yields a MAR of $962.74.
- Procedure code 72132 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 283, which, per OPPS Addendum A, has a payment rate of $277.48. This amount multiplied by 60% yields an unadjusted labor-related amount of $166.49. This amount multiplied by the annual wage index for this facility of 0.9997 yields an adjusted labor-related amount of $166.44. The non-labor related portion is 40% of the APC rate or $110.99. The sum of the labor and non-labor related amounts is $277.43. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $277.43. This amount multiplied by 200% yields a MAR of $554.86.
- Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99145 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

5. The total allowable reimbursement for the services in dispute is $1,517.60. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $962.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $962.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $962.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 6, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.